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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Written statement* submitted by International Educational Development, Inc., a non-governmental organization on the roster

The Secretary-General has received the following written statement which is circulated in accordance with Economic and Social Council resolution 1996/31.

[16 May 2011]

* This written statement is issued, unedited, in the language(s) received from the submitting non-governmental organization(s).

The right to health**

International Educational Development, Inc. and the Association of Humanitarian Lawyers[1] point out that the Human Rights Council, in its resolution 6/29 of 14 December 2007 article 1 (b), states that connecting Governmental actors, specialized agencies and programmes, NGOs, and international financial institutions possibly willing to cooperate with each other is crucial to realization of the right to health. (Operative paragraph 1(b)). The resolution stresses the importance of reporting on the best laws, policies, and practices most beneficial to the right's enjoyment and those best suited to overcoming obstacles encountered during implementation. (Operative paragraph 1(c)). Moreover, the Council encourages States to provide both financial and technical assistance to further the realization of the right. (Operative paragraph 4(d)). In this regard, there are new developments, both beneficial and unbeneficial that should be addressed by the Special Rapporteur.

First, in regards to the call to encourage national and international actors to create or scale up cooperation through partnership programs, there have been some successes. Most have involved partnerships to prevent or eradicate diseases where the capability to end them theoretically exists, but where the practical methods and programs had not been implemented. Some have been hugely successful and should be considered as models. The most notable of these has been the campaign to end Guinea worm disease, initiated by the Carter Center, WHO, UNICEF, and fellow partners. This campaign, which began in 1986, focuses on technical support, financial aid, and local cooperation with a clear goal, largely met, of eradicating a large majority of Guinea worm cases by 2010. The campaign created a health care infrastructure that focuses on education and preventative measures. Other partnership campaigns in are in place to eradicate and treat lymphatic filariasis (elephantiasis), river blindness, and schistosomiasis (snail fever). For example, the Global Alliance to Eliminate Lymphatic Filariasis includes academic and research institutions, advocacy groups, the health ministries in the 83 countries where the disease occurs, development agencies and foundations, UN agencies, non-governmental organizations and drug companies. The Bill and Melinda Gates Foundation is spearheading efforts to eradicate snail fever, hopefully with the same success as the effort to eradicate Guinea worm disease. WHO estimates that river blindness will be eliminated in the near future. There are other situations, such as the prevalence of goiter in rural China, that have not benefited much from partnership programs.

Second, in regards to the call to encourage laws and best practices, we agree with former Rapporteur Paul Hunt that a successful health work force depends on mid-level health workers, especially in developing countries and in areas of poverty where resources for high-level providers are so scant that there are very few of them. Currently, WHO's Global Atlas of the Health Workforce, 2011, reports that the large majority of African States and many south-east Asian States have less than 1 physician per 2000 persons. Delivering basic health care in these circumstances requires mid-level, and in certain circumstances, even lower-level health and sanitation workers. Ideally, high-level physicians that are culturally, geographically, and linguistically familiar with their regions should oversee the training and deployment of mid-lever and lower workers.

It is not surprising that many of the easily preventable illnesses, including those mentioned above, cholera, and malaria are rampant in the areas with the fewest high level health

** The Association of Humanitarian Lawyers, an NGO without consultative status, also shares the views expressed in this statement.

[1] AHL researcher Jacob Marx assisted in the preparation of this document.

providers, but as the successful models have shown, significant progress in eradication and treatment of diseases or reducing deaths and deficiencies related to pregnancy and childbirth has been made with middle and lower level workers doing most of the work. The largely successful "barefoot doctors" program in China, for example, brought basic health care to much of rural China. In our view, the serious health issues in much of the developing world will never be resolved without large-scale programs of training and deployment of mid and lower lever health and sanitation workers.

Third, regarding the call to all States for financial and technical assistance, serious problems occur because the developing world cannot afford many of the new advances, in terms of diagnostic and medical procedures, equipment and the high price of new drugs. Clearly, the disparity in medical care systems between the developed countries and developing countries is widening rapidly. Some new medicines, for example, cost more per week than the average person makes per month in many countries. While developing countries could do more in terms of medical spending per capita, some of them, even those with the best of intentions, cannot afford "modern" medicine. While there may be some hospitals and clinics in these countries, very few have much of what is considered indispensible in a hospital in the developed world. Many of these countries also have the most to do in combating preventable diseases and treatable conditions.

We urge the Special Rapporteur, perhaps in consultation with WHO, to propose some rights-based remedies to address the widening gap. One might be to focus on fewer, but fully modern regional hospitals, with more but more modest local clinics, perhaps largely staffed with mid-level health workers. States could facilitate cross-boundary travel to these hospitals. Another may be to provide incentives for increasing the numbers of temporary but well equipped facilities staffed by high-level providers. Another might be to provide more computers and internet technology in the developing world so that medical personnel have better access to medical information. We also encourage the Special Rapporteur to maintain a dialog with the special rapporteurs on food and water and sanitation, as these rights are often interrelated.

In conclusion, we urge the Council to extend the mandate of the Special Rapporteur. We further urge the Council again to (1) encourage States to take a more active role to create or scale up partnership programs, especially those that focus on ending all preventable diseases and conditions, using existing successful models as examples, (2) encourage States to push forward or renew commitments to train mid-level medical support providers and to disperse them in an equitable way, and (3) encourage developed States to provide developing States with more aid so as to decrease the disparity in health care systems around the world.